TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
THE BACK AND NECK INSTITUTE
ROBERT E. URREA, MD

Respondent Name
LIBERTY MUTUAL FIRE INSURANCE

MFDR Tracking Number
M4-17-3331-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
JULY 17, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We disagree with the denial. Our Operative Report Note indicates procedure 63044 was listed. Dr. Urrea performed redo decompression of the right L5 nerve, as well redo decompression of right and left S1 nerve root. All procedures are documented on the operative4 report."

Amount in Dispute: $916.93

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "63044 denied as this charge was not reflected in the report as one of the procedures/services performed. 63044 is Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, re-exploration, single interspace; **each additional lumbar interspace**. Documentation procedure is L5/S1 redo laminotomy decompression. Provider was paid for L5/S1 under CPT 63042. Only **one** interspace supported in operative report."

Response Submitted by: Liberty Mutual Insurance Co.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 4, 2016	CPT Code 63044	$916.93	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.

2. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
    - X133-This charge was not reflected in the report as one of the procedures or services performed.
    - W3, 193-The charge for this procedure exceeds the fee schedule allowance

Issues

1. What is the applicable fee guideline?
2. Is the respondent's denial of payment supported?
3. Is the requestor entitled to reimbursement for the disputed services?

Findings

1. The disputed service is subject to the fee guidelines outlined in 28 Texas Administrative Code §134.203.

2. 28 Texas Administrative Code §134.203(a)(5) states "Medicare payment policies" when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare."

   28 Texas Administrative Code §134.203(b)(1) states "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

   The requestor billed CPT codes 63042, 63044, 72020-26-59. The definition of these codes are as follows:

   - 63042-Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; lumbar.

   - 63044-Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc, reexploration, single interspace; each additional lumbar interspace (List separately in addition to code for primary procedure).

   - 72020-Radiologic examination, spine, single view, specify level.

   The Operative Report indicates the procedure performed was right L5-S1 redo-hemilaminectomy. The insurance carrier paid code 63042, but denied payment for code 63044 based upon "X133-This charge was not reflected in the report as one of the procedures or services performed."

   Based upon the Operative Report, the laminectomy was performed in the interspace located between the L5 and S1 segment. Because the procedure was performed only to one interspace, the respondent appropriately denied reimbursement for code 63044.

3. The Division concludes based upon the Operative Report and the code description, the requestor is not entitled to reimbursement.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

	A	08/09/2017
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.